District of Columbia
Health Information Exchange
Policy Board Meeting

Thursday, September 15, 2016
2:00 – 4:00 PM

Location:
One Judiciary Square
441 4th Street, NW
Main St. Conference Room, 10th Floor
Washington, DC 20001

Attendees:

Members present (13):

1. Chris Botts (DC Department of Health Care Finance) – Board Chair
2. Mary Jones-Bryant, RN (District of Columbia Nurses Association)
3. Kelly Cronin (The Office of National Coordinator)
4. Victor Freeman, MD (JA Thomas & Associates)
5. LaQandra Nesbitt, MD (DC Department of Health)
6. Justin J. Palmer, MPA (DC Hospital Association)
7. Donna Ramos-Johnson (District of Columbia Primary Care Association)
8. Tonya Royster, MD (DC Department of Behavioral Health)
9. Alison Rein (AcademyHealth)
10. Claudia Schlosberg (DC Department of Health Care Finance)
11. Eliot Sorel, MD (Medical Society of the District of Columbia)
12. Pete Stoessel (AmeriHealth)

Members present via teleconference (4):

1. Christian Barrera (Office of the Deputy Mayor for Health and Human Services)
2. Angela Diop, ND (Unity Health Care, Inc.)
3. Zach (Aaron) Hettinger (National Center for Human Factors in Healthcare/MedStar)
4. James Turner (Health IT Now Coalition)
5. Sakina Thompson (DC Department of Human Services)

Members absent (5):

	1. Edwin Chapman, MD (Private Practice and Leadership Council for Healthy Communities) 2. Brian Jacobs, MD (Children's National Medical Center) 3. Bryan Sivak (Robert Wood Johnson Foundation and Civic Hall) 4. Archana Vemulapalli (DC Office of the Chief Technology Officer) 5. William Ward (Catholic Charities) **Non-members present (4):** 1. Kory Mertz (CRISP) 2. Jim Costello (DCPCA) 3. Melisa Byrd (DHCF) 4. Selwyn Eng (Mary's Center) *DHCF Staff*: Dena Hasan, Jordan Cooper, and Michael Tietjen
AGENDA	
Call to Order **Announcement of Quorum**	Mr. Botts called the meeting to order at 2:05 PM. At 2:09 PM Mr. Botts announced that there was not a quorum. Quorum was later announced at 3:39 PM with additional public members present.
Approval of the Minutes	The June 23, 2016 minutes were not approved due to the lack of a quorum at the beginning of the meeting. Approval of the June minutes will occur during a Special Session that will be held in October (specific date is TBD).
Presentation on Michigan's HIE Environment	Mr. Botts introduced Meghan Vanderstelt, the Policy Director of the Michigan Department of Health & Human Services (DHHS), to present (via WebEx) an overview of Michigan's HIE environment. Ms. Vanderstelt began her presentation by stating that Michigan's HIE efforts started about ten years ago at the behest of the governor who articulated the value of and need for HIE. Calling upon various stakeholders, Michigan created a 'Conduit for Care' white paper that became the blue print for the guiding principles for their HIE ecosystem. Michigan employed a public-private governance model by creating a new entity with close ties to the state government but which remains outside of complete state control. Michigan is fostering the creation of an HIE ecosystem that utilizes common data sharing use cases and promotes multi-stakeholder participation among hospitals, health plans, and state government. Michigan already had a number of HIEs in existence (which would come to be referred to as qualified health information organizations) and sought to expand the HIE ecosystem with a larger governance structure. Ms. Vanderstelt continued, adding that DHHS sought to establish a designated nonprofit entity to create a network of networks (with qualifying organizations) with shared services, which would come to be called the Michigan's Health Information Network (MiHIN).

	The MiHIN is a network that facilitates the statewide sharing of health information in Michigan, though it is not an HIE. Rather, it uses a central hub and spoke model that is designed to reduce duplication of effort, waste, and expense. MiHIN is an independent not-for-profit organization with a board of directors that includes two representatives from DHHS (one represents Medicaid and one represents public health). Additionally, MiHIN has an Operation Advisory Committee that addresses daily operations, HIE planning, privacy, and security items, among other topics. Michigan also formed a separate group in 2006 called the Health IT Commission, which is comprised of gubernatorial appointees, to oversee the specific policies that govern information exchange. MiHIN's statewide Shared Services cloud has a multitude of different organizations that are part of the network and participate in a variety of different use cases for data exchange. MiHIN serves as a single point of entry for Trusted Data Sharing Organizations (TDSOs) to access information on patients across the state. Dr. Nesbitt asked Ms. Vanderstelt if MiHIN is a single, vendor-agnostic, technological solution for data exchange or if MiHIN is really a multitude of solutions that are aggregated under one umbrella. DHHS' Kim Bachelder, an HIT Senior Analyst, responded stating that MiHIN is a vendor-agnostic statewide facilitator that standardizes messages. MiHIN facilitates the interoperable exchange of data by creating a standard method of data exchange using standard data elements. The legal infrastructure for TDSOs is predicated upon one large Data Sharing Agreement and one Master Use Case Agreement that must be signed by all qualifying organizations seeking to participate in MiHIN. Each qualifying organization has the additional opportunity to then select which use cases they would like to benefit from. A use case is defined as a specific data sharing scenario with a specific purpose in which a certain type of data is exchanged among a defined set of people and systems. Each use case may have different access restrictions, rules for data-use, cost recovery fees or charges, and technical requirements. MiHIN created a Use Case Factory in which anyone can submit an idea for a use case and become its champion. As part of this process the use case is defined and evaluated, funding is identified, the use case is piloted, and then the use case is refined. It then goes to the MiHIN Board, where it is voted to be implemented, measured, and adopted (a 68% adoption rate is considered to be successful). One of the greatest drivers of the Use Case Factory was the involvement of Blue Cross Blue Shield of Michigan (BCBSMI), which created an incentive program for their providers to participate with the Use Case Factory, which lead to a significant increase in ADT messaging once the incentive program was instated. Ms. Cronin pointed out that MiHIN goes beyond being a standards-setting organization and actually centralizes some of its Shared Services. She added that this allows Medicaid, private payers, and many other parties in the state to leverage MiHIN as a one stop shopping service for their health-related data exchange needs. Ms. Bachelder affirmed Ms. Cronin's point, stating that there are baseline standard use cases which promote interoperability, which she defined as sharing the right data, for the right person, at the right time, at the right point of care. Example use cases include the Active Care Relationship Service (ACRS), Provider Health Directory, and Common Key Service Use Case. ACRS shares data between providers and patients, storing up-to-date provider information in a provider health directory, demographic

	information on the patient, and electronic service information for the provider such as which EHR the provider is using and where the information ought to be sent. ACRS compliments the Provider Health Directory by linking providers to patients with whom they have an existing relationship. MiHIN is on the verge of implementing a querying functionality and is currently exchanging millions of ADT messages among providers based upon relationships established in the ACRS. Ms. Cronin added that ACRS is a valuable tool that can enable the quality measurement enterprise to hold an entire care team accountable for an outcome and can route the right ADT message to the right provider to prevent an avoidable readmission; ACRS is an important tool for both measurement and for accurate information exchange. Dr. Freeman asked for further clarification on how the use of ADTs varies by hospital and if there is significant variance around the quality of information being fed into MiHIN. In response, Ms. Vanderstelt said the first five years of the ten year journey to date was spent overwhelmingly on creating a legal framework that would support and structure data sharing in Michigan. Having now established the rules of the road of data sharing in Michigan, MiHIN is now focused on how interoperable data is used. Mr. Botts asked how funding is identified to support each use case. Ms. Vanderstelt replied that a variety of stakeholders can sponsor a use case; for example, BCBSMI saw great value in supporting one particular use case, so they chose to sponsor it. It is apparent that the same use cases are of value across different programs and among different stakeholders. MiHIN seeks to convene these payers and clinical organizations and in so doing determine how to standardize a program or product to be of the greatest benefit to the greatest number of stakeholders. Ms. Rein asked how long it takes a use case to cycle through the Use Case Factory. Ms. Vanderstelt responded that, for example, the technical ability to facilitate the Immunizations Syndromic Surveillance use case scenario was pushed through relatively quickly. However, it is common for state laws or regulations to slow down the process. With a best case scenario use cases can be adopted within a month. Other projects can last for years; for example, the electronic consent management system project has lasted for four years due to legal, privacy, and other regulatory obstacles. Ms. Vanderstelt highlighted that MiHIN has sought and received HITECH 90/10 match funding through CMS to build MiHIN infrastructure, whereas subsequent funding for continual operations can be met with 50/50 matching funds through ONC's HIE Cooperative Agreement to support MiHIN. MiHIN is sustained through mixture of funding sources, including the support of commercial payers sponsorship, transaction fees, annual membership fees for qualifying organizations, federal matching funds, and through transactional fees generated by the provision of services to other states. Ms. Cronin then asked how MiHIN engaged private payers, particularly from a financial perspective. According to Ms. Vanderstelt, the Executive Director of MiHIN expended a great deal of effort engaging the private payer community across Michigan. BCBSMI support was largely as a result of his efforts.

Presentation on DHCF's Medicaid Data Warehouse Initiative	Mr. Botts introduced John Sumner, DHCF's Data Warehouse Project Lead, to discuss DHCF's Medicaid Data Warehouse (MDW) modernization project. The MDW initiative began in January 2014 and will formally go-live in September 2017 for external users. There will also be an interim roll out of new MDW applications, features, and solutions on September 30, 2016 for internal DHCF-users only. Mr. Sumner began by defining a Medicaid Management Information System (MMIS) as a system that collects and processes Medicaid claims for payment. DHCF's MDW was established in 2007 pay MMIS claims effectively and efficiently, which it continues to successfully do. The current MDW upgrade is being undertaken to improve the department's ability to analyze the claims data. Currently Medicaid Managed Care Organizations (MCOs) and Medicaid Fee For Service (FFS) providers' claims are filed in MMIS. Xerox is serving as the Datamart vendor (with a product called Cognos). Cognos is tasked with analyzing the MMIS data but is limited in its ability to analyze longitudinal data trends (limited to a 48 month look-back period) and is limited to 400 data elements. The current system is not capable of cross-walking systems (e.g. claims, recipients, etc.). To alleviate these challenges, among others, DHCF is in the process of expanding the capabilities of its MDW. The expansion to a more robust Datamart design will entail the construction of a DHCF web portal, a case management system, and, at CMS' suggestion, the deconstruction of MMIS into modular components. These modular components will break a query into multiple nodes of computing to get back results much faster than DHCF's current MDW, reducing the time that it takes to execute a query sometimes from a few hours down to five minutes. The new Datamart will be capable of reporting 1,000 data elements (increasing the amount of data elements by 250%) to CMS through T-MSIS on a monthly basis. The updated MDW will have augmented data visualization capabilities courtesy of Tableau and a SAS visual analytics tool. The look back period of the Datamart will increase from 5 to 20 years, its data processing capabilities will be expanded to handle 20 Terabytes of data. In sum the upgraded MDW will provide a more robust, enterprise-wide view of the entire MMIS claims database. The eventual architecture of the MDW will become a single source of truth for reporting purposes. Both internal and external stakeholders will enjoy easier access to and use of MDW reporting capabilities. It will be used to establish baselines more quickly, advance the quality measurement enterprise, and will facilitate the identification of longitudinal trends. Dr. Freeman asked whether the new MDW upgrade would be able to accept health data from public schools in the District. Mr. Sumner replied that the MDW infrastructure is meant to ingest any data from any internal or external source. Once a data source is identified, the MDW infrastructure necessary to accept the data, already being in place, will be able to execute a MOU within a matter of days instead of a matter of months. Mr. Botts added that it is up to the Board to understand the capabilities of the MDW and to provide recommendations for future

	iterations of MDW capabilities. Dr. Sorel asked about data security for the MDW and Mr. Sumner said that the backend of the MDW sits in a high security data center owned and managed by OCTO. Dr. Sorel then asked how the MDW will allow the District to address all determinants of health. Ms. Schlosberg said that system was designed and built to meet internal needs but it is clearly being built with the capability to service additional external needs. With the MDW upgrades it will be possible to gain a 360 degree view of an individual. Dr. Sorel responded stating that the Board needs to ensure that the MDW collects data on all possible determinants of health and that the Board ought to set a timeline and make a decision about when certain provisions will be implemented and not just kick the can down the road. Ms. Cronin suggested that future use cases concerning the MDW be determined by the Board in part with provider input on usability of the MDW (once it becomes available to external users).
Updates • IAPD-U for FY16-17 • Data Mapping Initiative (Phase 2)	Mr. Botts said that DHCF's IAPD-U was approved by CMS on July 19th thus giving DHCF funding *authority* to release public grants to facilitate the design and implementation of the five initiatives proposed in the IAPD-U. DHCF continues to wait on formal approval of its draft grant language from CMS in order to *release* the actual application request to the public. Select of a grantee(s) is expected in the Fall of 2016. Dr. Freeman asked for a reiteration of the five IAPD initiatives and Mr. Botts enumerated them: 1. Care profile 2. eCQM dashboard 3. Specialized Registry for pre-natal care 4. Analytical Population dashboard 5. Ambulatory connectivity and support Mr. Botts updated the Board on the Data Mapping Initiative. He said that DOH data systems mapping (e.g. health surveillance, PDMP, etc.) will continue through the end of September 2016. He also notified the Board that there will be an expansion of the Data Mapping Initiative into the LTSS and Behavioral Health arenas to prepare DHCF to take advantage of the opportunities presented by the CMS State Medicaid Director letter sent on February 29, 2016.
Reports • Sustainability Subcommittee Report	Ms. Rein opened up her report on the Sustainability Subcommittee's September meeting by summarizing the first hour as a discussion about the specific mission of the Subcommittee. Additionally, the Subcommittee walked through the materials created as part of the District's Data Mapping initiative with the contractor, Clinovations GovHealth. Towards the end of the meeting the Subcommittee agreed that more concrete action items are needed in addition to more information about the current needs of different stakeholders. On the topic of seeking out input from various stakeholders, Dr. Sorel requested that a private payer in the District present to the entire Board about a 'culture of health.' Ms. Rein said that the Subcommittee will create a discussion guide and have listening sessions in order to ascertain the stakeholder needs. As part of these listening sessions the Subcommittee will seek to learn what needs are being met (and/or not met) by the current HIE environment. Ms. Rein requested that the Board provide direction to the Subcommittee regarding who or which organizations

	should be included in these active listening sessions.
Discussion • Mission Statement • Long-term Goals • Short-term Objectives	Mr. Botts opened discussion on the governance homework for which members submitted comments. Dr. Royster began the discussion by noting that, on the Mission Statement, options number 1-4 are mostly wordsmithing, with option number 5 is the simplest. Dr. Freeman expressed his preference for number 1 which most closely resembles the original. Ms. Cronin, Dr. Diop, and Mr. Hettinger showed a preference for option number 5. Ms. Rein said that option number 5 has a lack of clarity and is quite vague. Mr. Hettinger said that he supports option number 5 because it focuses on the health and welfare of community members and is less about healthcare or outcomes. The discussion shifted to the Long-term Goals. Dr. Sorel said that the vision is inadequate because it makes no mention of promoting health and is instead only about healthcare; HIE, he said, should incentivize health promotion. Mr. Palmer suggested that perhaps the MDW may be more well-positioned to promote health than the HIE. The Board was not in agreement about the second clause of the original long term goal statement. Ms. Schlosberg said that the second clause reflects data flow in the District. Dr. Royster and Ms. Rein said that the second clause is only a reiteration of the first clause. Mr. Botts then recapitulated all three clauses which led to debate about wordsmithing the first clause and agreement that 'exchange' be added before 'accessible' and 'actionable.' Dr. Freeman suggested dropping the last 2 clauses all together. Ms. Schlosberg agreed. Mr. Botts responded stating that the Board should have more than one long term goal. Ms. Schlosberg said that the third clause relates more to more practice transformation and that the first task of the Board ought to be to ensure that we have adequate infrastructure to exchange necessary health-related data. Mr. Botts then suggested that the first clause can be part of the mission statement. Ms. Rein then articulated her opposition to the third clause owing to its lack of specificity. While option number 5 was originally unanimously adopted, several members of the Board, including Dr. Royster, Ms. Rein, and Justin Palmer, asked that the final vote on the Board's goals and objectives be postponed to provide time to review and digest the various options. Ms. Schlosberg said that we need to focus on the work of the Board as soon as possible and therefore the Board should not postpone the vote so that subsequent meetings will not be consumed with this topic again. Owing to general disagreement, Mr. Palmer suggested that a separate call be set-up prior to the next Board meeting to discuss only this topic; the motion carried and DHCF staff were instructed to coordinate a Special Session in October 2016.
• **Adjournment** [4:00 PM]	The meeting adjourned at 4:05 PM.